2011-08-09 14:47

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4237351160 P 18/24 PRINTED: 08/08/2011

Division of Health Care Fac	lities			PRINTED	08/08/20 APPROV
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE	A. BUILO	TIPLE CONSTRUCTION	(X3) DAYE S	SURVEY
NAME OF PROVIDER OR SUPPLIER	TN8503	D, WING	V	-	3/2011
CENTER ON AGING AND HEA	ALTH 186	REET ADDRESS, CITY,	STATE, ZIP CODE	CODE	
			OKIVE		
	NTEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TH DEFICIENCY		COMPLE DATE
N 000 Initial Comments		N 000			
2011, no deficiencie complaint #28183.	cansure survey and com 3 conducted August 1-3, 25 were cited in relation t	plaint			
N 623 1200-8-606(3)(b)2		N 623			
(3) Infection Contro	ol.		No residents were affect		
specially trained anii except as addressed therapy programs. Its policies and proceanings will be exclusively be determined of the facility perform personnel.	ther animals shall not be of the facility except for mals for the handicapped by facility policy for pet the facility shall designated areas where the facility shall designated. The areas designated. The areas designated by medically trained	d and the in	Two dogs and one cat we veterinarian and yearly were administered on 8/Activities director will deveterinarian for needed and other visits monthly	vaccinations //1/2011.	
to date for three of the therapy within the fac	n and interview, the facili nnual vaccines were cur ree animals used for pet illty.	ty	Vaccination summary to to administrator by activ director monthly. Will π compliance thru QA con	rities nonitor	9/14/11 &
The findings included			Administrator, Director	of Nursing	Ongoing
AUGUST 1. ZUTT AF W.	Itial tour of the facility on 35 a.m., revealed the faci residents, two dogs and		Safety Director, and Dep Managers, and quarterly Medical Director.	partment	
inclination of the well					
on of Health Core Facilities	NA	· · ·			
TATORY DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVES	SIGNATURE	at mount , bo	وري	DATE
FORM		#400	1sa mineral de	0/2	6/2011

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVI		(X1) PROVIDE	R/SUPPLIER/CLIA ATION NUMBER:	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE (	FORM APPROVED  (X3) DATE SURVEY COMPLETED	
			****	DORESS, CITY, STA	TE. ZIP CODE	08/0	3/2011	
				TH MOHAWK D TN 37650	RIVE			
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	ATEMENT OF DEF Y MUST BE PREC SO IDENTIFYING	ICIENCIES	PREFIX TAG	PROVIDER'S PLAI (EACH CORRECTIVE CROSS-REFERENCES	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE	COMPLETE	
N 823	Continued From pa	ige 1		N 623	DEFIC	IENCY)	DATE	
	Review of the facilitianimal's vaccine rewere due for the an interview with Activity 2011, at 4:00 p.m., station, confirmed the required annual vaccined annua	inual vaccine ities Director of the East W	ine inree pets in April, 2011.					
E FORM	Care requities							
			SUSM11			if continuation offeet 2 of 2		